Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29407
SAN ANTONIO TX 78229-5907

Respondent Name
TPCIGA FOR LUMBERMENS MUTUAL CO

Carrier's Austin Representative Box
Box Number 50

MFDR Tracking Number
M4-12-3462-01

MFDR Date Received
JULY 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient states services which were provided were covered under worker's compensation claim."

Amount in Dispute: $42.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Earle was not the treating doctor at the time of the referral. Dr. Earle was referred into the case by Dr. Beard. Dr. Beard was not the treating doctor at the time of the referral. Dr. Beard did not become the treating doctor until 1/13/12. The service dates in question precede the date upon which Dr. Beard became the treating doctor. The approved treating doctor prior to that time was Dr. Vinal. He never referred the claimant to Dr. Earle. Thus, those services were not at the direction of the treating doctor (Dr. Vinal) or the treating doctor's referral."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2011	CPT Code 71020-26	$17.14	$0.00
	CPT Code 72110-26	$25.12	$0.00
TOTAL		$42.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021, effective September 1, 1993, requires all treatment, except in emergencies, to be

approved by the treating doctor.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 080-001-Review of the bill has resulted in an adjusted reimbursement for the entire bill of $0.00.
   - 165-Referral absent or exceeded.
   - 910-048-Payment denied reduced for absence of or exceeded referral.
   - 94-Processed in excess of charges $0.00.
   - 18-Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use with Group Code OA).
   - 476-The charges are duplicates of bill.

Issues

1. Did the treating doctor approve or recommend the disputed treatment? Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code 408.021(c) states "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

   On the disputed date of service, the claimant's treating doctor was James Kevin Vinal.

   The documentation does not support that the disputed treatment was approved or recommended by the employee's treating doctor; therefore, the disputed services were not in compliance with Texas Labor Code 408.021(c). As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/08/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.